A Citizen's Guide to Enrollment in West Virginia:

Health Insurance Options Under the Affordable Care Act

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WVAHC
West Virginians for Affordable Health Care

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Glossary of Terms and Acronyms

ACA: The Affordable Care Act, the national health reform law passed by Congress in 2010.

Actuarial value is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, consumers would be responsible for 30% of the costs of all covered benefits. However, an individual consumer could be responsible for a higher or lower percentage of the total costs of covered services for the year depending on your actual health care needs and the terms of your insurance policy.

Advance payment for premium tax credits (APTC) are subsidies to assist individuals and families with their monthly premium payment.

CHIP: The Children's Health Insurance Program provides insurance coverage to children in families earning too much to qualify for Medicaid coverage, up to 300 percent of the federal poverty level.

Cost sharing reductions (CSR) are subsidies to assist individuals and families with deductibles, copayments or co-insurance payments made for medical services.

FPL: Federal poverty level is the amount of money that an individual or family earns and is used to determine eligibility for Medicaid, CHIP and subsidized private insurance plans. The federal poverty level varies by income and family size, including families of one.

Health Insurance Marketplace is a marketplace where approved private health insurance products are sold to individuals and families. The policies can be purchased in person or through a web site, a toll free call center, or the mail.

HHS: United States Department of Health and Human Services.

IPA: In-person assister. These are trained individuals hired by a vendor through a contract with the Offices of the Insurance Commissioner.

IRS: Internal Revenue Service.

MAGI: Modified adjusted gross income is an individual's or family's annual adjusted gross income with a few exceptions. Income from educational grants and awards other than living expenses and certain income to American Indians and Native Alaskans are excluded from the MAGI calculation. MAGI income includes all Social Security income, foreign income and income from tax exempt interest. When determining eligibility for Medicaid, lump sum payments are treated as MAGI income only in the month they are received.

Medicaid is the joint federal and state health insurance program that currently covers low-income individuals and families, people with disabilities, people receiving long-term care services, foster children, and women in the Breast and Cervical Cancer Program.

OIC: West Virginia Offices of the Insurance Commissioner.

Out-of-pocket (OOP) maximum is the total amount that an individual or family pays during a year in deductibles, copayments or co-insurances before the insurance company pays one hundred percent of all future legitimate claims.

Qualified Health Plans (QHPs) are plans that have been approved by the West Virginia Offices of the Insurance Commissioner for sale in the Health Insurance Marketplace or the SHOP Marketplace.

Reconciliation is a process conducted by the Internal Revenue Service when taxes are filed at the end of the year to determine if an individual or family received more (or less) of a tax credit for premium assistance than they were entitled to in the previous year.

Self-attestation is what a person says is his or her income, family size, states where he or she lives, and other eligibility criteria.

SHOP Marketplaces: Small Business Health Options Program is a marketplace where small businesses can purchase health insurance for their employees.

SSA: Social Security Administration.

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I: Introduction

The information can be overwhelming for a person who really just wants to become a community assister. It's important for community assisters to learn the basics, but they don't have to memorize every fact.

Uninsured people across West Virginia and the nation will have access to health insurance coverage, thanks to the Patient Protection and Affordable Care Act (ACA).[1] Beginning on October 1, 2013, enrollment will begin for uninsured state residents who qualify. Coverage under the new health plans will begin as early as January 1, 2014.

If there are enough West Virginians trained and helping our neighbors, we could enroll up to 100,000 people in West Virginia, reducing the number of uninsured by more than a third. We have an once-in-a-lifetime opportunity to provide financial and health security to thousands of hard-working West Virginians.

Being uninsured is more than an inconvenience. People without insurance "live sicker and die earlier" than those with insurance. Each year, an estimated 18,000 Americans die prematurely because they lack insurance coverage.[2] That translates into four preventable deaths every week in West Virginia among the uninsured.

New Insurance Options under the Affordable Care Act

The Affordable Care Act establishes a new Health Insurance Marketplace (called the Marketplace in this booklet). People who need health insurance can go to the Marketplace, find out what they're eligible for and apply for the plan that's right for them. They can apply through a web site, by phone, by mail, or with personal assistance. Both the web site and the toll-free call center will be operated by the US Department of Health and Human Services (HHS).

This application process is intended to be a "no wrong door" approach. With one application, the Marketplace determines what type of coverage an individual or family is eligible for, based on their income and other factors. There are four kinds of coverage.

1. **Medicaid** will cover everyone who lives in West Virginia, is a US citizen, is under age 65, and earns less than 138 percent of the federal poverty level (FPL), $26,951 a year for a single mom with two kids or $15,856 for a single adult.

1 The Patient Protection and Affordable Care Act was amended by the Health Care and Education Reconciliation Act of 2010. These two statutes are referred to as the Affordable Care Act or ACA throughout this publication.

2 Institute of Medicine, "Hidden Costs, Value Lost: Uninsured in America," The National Academies Press, Washington, D. C. (2003).

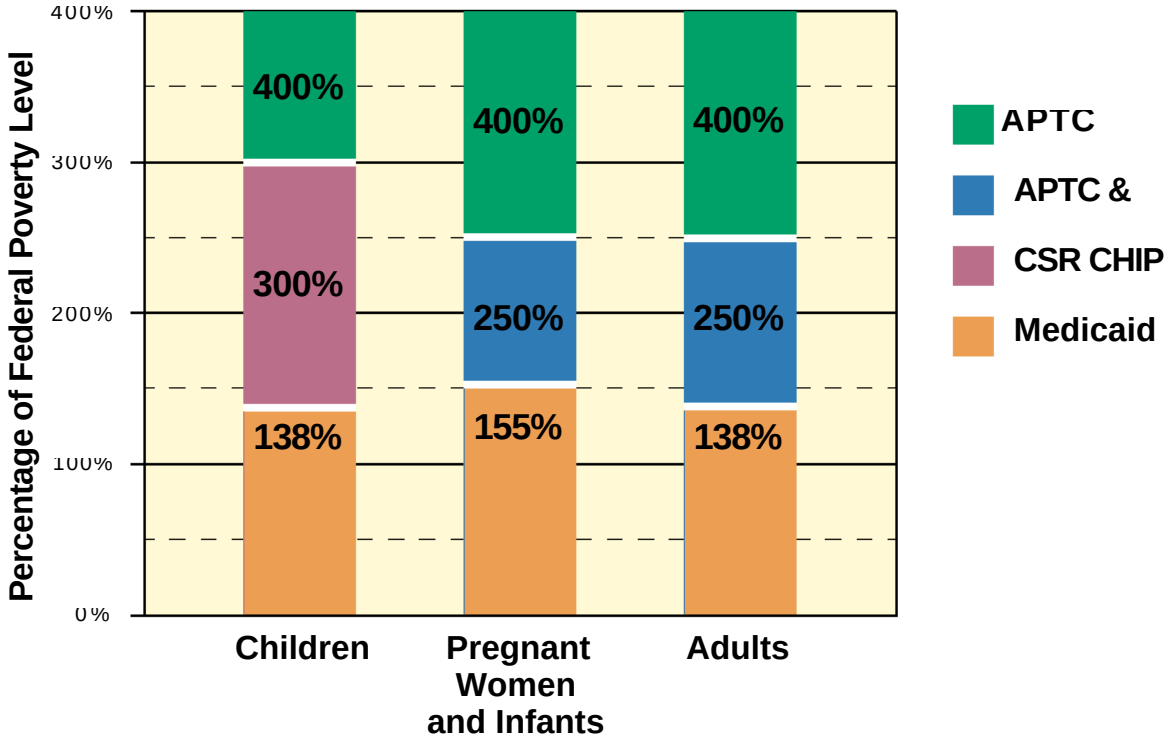
2. The **Children's Health Insurance Program (CHIP)** will continue to be available for income-eligible children, but current enrollees who are in families with income below 138 percent of FPL will be transferred to Medicaid.

3. **Private health insurance plans** will compete to sell "qualified health plans." There are significant premium subsidies on a sliding scale for individuals and families earning between 100 percent and 400 percent of the federal poverty level. In addition, there are subsidies for deductibles, copayments and co-insurances for individuals earning less than 250 percent of the federal poverty level. Families above 400 percent of the FPL earn too much to qualify for subsidies, although they can enroll in a plan and pay the entire monthly premium.

4. The **Small Business Health Options Program (SHOP) Marketplace** enables businesses with fewer than 50 full-time employees to purchase qualified health plans in the SHOP Marketplace. This booklet focuses primarily on the enrollment process for Medicaid, CHIP and QHPs for individuals and families in the Marketplace. The SHOP Marketplace is discussed separately.

CHART ONE

Income Eligibility for Insurance Options in the Marketplace



APTC is advance payment for premium tax credits or subsidies for premiums.
CSR is cost sharing reductions, or subsidies for deductibles, copayments and co-insurance.
Infants are children under age one.

How Income Eligibility is Determined

The Marketplace will make the eligibility decisions based on access to the "federal hub" which includes information from databases from the IRS, the Social Security Administration, Homeland Security and other state and federal agencies. All three of the insurance options in the Marketplace (Medicaid, CHIP and qualified health plans) will determine income using the modified adjusted gross income (MAGI).

Medicaid and CHIP will use a different time frame for determining a family's income than QHPs in the Health Insurance Marketplace. Both Medicaid and CHIP will use a family's current earnings in the month they apply, while the eligibility for subsidies for private insurance coverage in the Health Insurance Marketplace will use what a family expects to earn during the coverage year: for example, what a family is expected to earn in 2014. Assets are not considered in determining eligibility for any of these health coverage options.

In general, Medicaid and the Marketplace will use what the applicant states is his or her family size unless the Marketplace has information to the contrary. Together, the MAGI and family size will determine a family's federal poverty level (FPL). The FPL determines the coverage and subsidies for which a family or individual qualifies. (See Appendix B for 2013 FPLs by family size.)

Assistance to Help People Enroll

HHS will operate a web site and a toll-free call center where people can get assistance in the enrollment process. In addition, there will be at least six different entities in West Virginia providing personal assistance with enrollment.

Insurance agents and brokers are licensed to sell insurance policies. In order to be licensed, insurance agents and brokers must complete a 40-hour course, pass a certification test, and obtain continuing education credits to remain current. Insurance agents are funded though commissions paid by insurance companies for selling insurance policies, while brokers can be funded by the consumers they represent or by insurance companies. Not all insurance agents and brokers are anticipated to participate in the Marketplaces. Those who do will have a solid understanding of the private insurance market including enrolling individuals in qualified health plans and assisting both employers and employees in the SHOP Marketplace. They are unlikely to play a significant role in enrolling people in Medicaid.

Navigators will be selected, funded and supervised by HHS. Navigators will receive grants to conduct public education and provide impartial assistance to individuals, families and small employers with enrollment in Medicaid, CHIP, qualified health plans, and SHOP policies. In the first year, the funding for these positions is limited to only $600,000 for the entire state. The requirements to be a navigator include 30 hours of web-based education, passing a certification test, continuing education

and compliance with Marketplace standards. Navigators should have a solid understanding of Medicaid, CHIP and the private insurance market.

In-person assisters (IPAs) will be very similar to navigators. An estimated 230 paid positions will be selected by a statewide vendor under contract with the West Virginia Offices of the Insurance Commissioner (OIC). IPAs are likely to have similar training and certification criteria as navigators: 30 hours of training and passage of a certification test. Funding for the IPAs will be through federal grants that will expire at the end of 2014. Most of the IPAs will be seasonal employees with approximately only 30 ongoing positions after March 31, 2014. As with navigators, IPAs should have a solid understanding of Medicaid, CHIP and the private insurance market, although the IPAs will not enroll employers or employees in the SHOP Marketplace.

Certified application counselors are trained assisters located in facilities, such as hospitals, who can provide assistance to someone being admitted to the facility. Generally, certified application counselors will not be doing outreach and public education. Funding for certified application counselors is very uncertain and cannot include federal resources. Certified application counselors should have a solid understanding of Medicaid, CHIP and the private insurance market.

Department of Health and Human Resources employees are generally located in the DHHR offices in the county seat. They are skilled at enrolling people into Medicaid and CHIP but will not be involved in enrolling people in private health insurance plans.

Community assisters will be trained community volunteers and staff in nonprofit community agencies. Unless paid for by an agency or through foundation funding, they will be unpaid positions. No specific training or certification is required for community assisters, although some will voluntarily complete the training and take the certification to become navigator or IPA. Community assisters will generally connect the uninsured to more highly skilled assisters, both personal assisters or through the call center. Depending on the level of training and expertise, community assisters could assist individuals and families with uncomplicated enrollments.

Other community assisters will want to focus on bringing together the uninsured with trained navigators, IPAs or insurance agents by arranging public education meetings and enrollment opportunities at a church, synagogue, community health center, volunteer fire department, local pharmacy, public library, etc.

West Virginians for Affordable Health Care will provide local and regional workshops to train community assisters in the fundamentals of enrollment. These workshops will be available beginning in July 2013.

West Virginia will need a large number of knowledgeable and trained people for enrollment to be successful. Everyone has an important role to play to make enrollment successful.

The information provided below can be overwhelming for a person who really just wants to become a community assister. It's important for community assisters to learn the basics, but they don't have to memorize every fact. West Virginians for Affordable Health Care will compile a list of resources by county, so that community assisters will know who they can contact for professional help. Connecting the uninsured to those who can enroll them in a health plan is a vitally important task and one that will have significant impact on the lives and wellbeing of our neighbors, friends and relatives.

Neutrality

Navigators are required by HHS regulations to "provide information and services in a fair, accurate, and impartial manner," and HHS is considering applying this standard to IPAs too. Community assisters should also be meticulously neutral on which insurance plan a consumer selects. It is ethically inappropriate for community assisters, IPAs or navigators to select or recommend a particular plan or company to an individual or family. Only licensed insurance agents and brokers may make a selection or recommendation to a consumer.

Confidentiality

All assisters will be required to keep personal information, such as income, social security number and immigration status, strictly confidential. There will be penalties for any assister who betrays confidentiality.

Medicaid will have a two-step process for enrollment. The Marketplace will first make the eligibility determination while the Bureau for Medical Services, West Virginia's Medicaid program, will enroll individuals and families that the Marketplace has found eligible. The Medicaid program will not re-evaluate applicants but accepts the Marketplace's determination of eligibility and enrolls them in Medicaid "promptly and without undue delay."

Timelines

The Marketplace will begin enrolling low-income individuals and families on October 1, 2013, with coverage beginning as early as January 1, 2014. Unlike the qualified health plans sold in the Health Insurance Marketplace, there are no limited-enrollment periods for Medicaid; people can apply at any time. The state Medicaid office will determine when coverage becomes effective for newly enrolled individuals and families after January 1, 2014.

Eligibility Criteria for Medicaid

The ACA expands Medicaid eligibility for the **MAGI population** to include all children and adults who meet income and other guidelines. The ACA leaves current eligibility intact for traditional Medicaid programs, such as people who are blind or disabled, in need of long-term care services, or eligible for the Breast and Cervical Cancer Program. (See Chart 2.)

The Marketplace will determine eligibility for the MAGI population, which includes children, parents and caretakers, adults without children, and pregnant women. Eligibility for the MAGI Medicaid populations has five components: (1) income, (2) family size, (3) citizenship and immigration status[3]; (4) age less than 65 years old, and (5) state residency. Medicaid for the MAGI population covers "essential health benefits" that include physician office visits, in-patient and out-patient hospitalization, prescription drugs, and more. (See Appendix A for details on the Medicaid essential health benefits.)

If an applicant is not eligible for MAGI Medicaid benefits, the Marketplace will, if appropriate, refer the applicant to the Bureau for Children and Families to determine possible eligibility for traditional Medicaid programs. These programs may offer richer benefits, but enrollment takes much longer. If an applicant is eligible for MAGI Medicaid or subsidized premiums for private insurance plans and may be eligible for traditional Medicaid, he or she should enroll in the MAGI Medicaid program or the subsidized private insurance plans while determination for traditional Medicaid programs is being made.

3 Legal immigrants are not eligible for Medicaid until they have been legally present in the United States for five years. States can, however, submit a state plan amendment to HHS to remove this five-year waiting period for pregnant women and children. West Virginia has not done so as of April 2013, although pregnant women receive coverage under the emergency Medicaid program.

CHART TWO

Medicaid Programs and Populations

MAGI Population	Non-MAGI Populations or Traditional Medicaid
■ Infants and pregnant women ■ Children, up to 19th birthday ■ Adults, single and married, parents and non-parents, up to 65th birthday	■ People who are blind or disabled ■ People receiving SSI benefits ■ Medicare recipients who are dually eligible for Medicaid ■ People eligible for "medically needy" coverage due to high medical expenses ■ Long-term care, including nursing homes and home and community-based services

Income

Medicaid will use a new methodology for determining household income called the Modified Adjusted Gross Income (MAGI). This method adopts the income tax definition of what counts as income. In general, income that is taxable will be counted for the purpose of determining Medicaid eligibility.[4] The current monthly MAGI is used to determine income eligibility for Medicaid.

When an applicant starts an application on the Marketplace web site, the latest IRS tax return will be listed if the applicant filed taxes the previous year.[5] These will be the 2012 tax returns: income that is at least nine months old. If the applicant agrees that the amount listed is his or her current income and the income is below 138 percent of FPL (or 155 percent of the FPL for infants and pregnant women), then the Marketplace accepts that amount and approves the applicant's income eligibility.

If the applicant's stated income differs from the IRS tax returns, then the Marketplace checks to determine whether the information is "reasonably compatible," meaning that the information provided by the applicant and the information provided by IRS are both either above or below the appropriate FPL. Here are three examples:

- If the applicant says that he or she is earning 100 percent of the FPL, and the IRS says they are earning 110 percent of the FPL, that is reasonably compatible because both figures are below the Medicaid income threshold. In this case, the Marketplace would determine that the applicant meets the Medicaid income qualifications.

4 There are exceptions from taxable income in determining MAGI income. Income not included in the calculation of MAGI includes educational grants and awards other than living expenses, lump sum payments which are only counted in the month received, and certain income to American Indians and Native Alaskans. MAGI does include all Social Security income, foreign income and income from tax exempt interest.

5 It is expected that in 2014, only the IRS database will be available to the Marketplace. In the future additional databases such as the West Virginia Unemployment Compensation database may be used by the Marketplace to verify income.

- If an applicant says that his or her income is 160 percent of the FPL and the IRS says it's 170 percent of the FPL, the amounts are reasonably compatible because both figures are above the Medicaid eligibility limit. In this case the Marketplace would determine the applicant ineligible for Medicaid and determine eligibility for traditional Medicaid or eligibility for assistance with a qualified health plan.

- If the applicant reports income of 120 percent of the FPL, but the IRS database reports income of 160 percent of the FPL, the information is not reasonably compatible, and the Marketplace will try to verify income electronically with other databases. If the Marketplace is unable to verify the income electronically, the applicant will be given a reasonable period of time to provide additional information. Ultimately, if the applicant cannot provide information demonstrating that his or her income is below 138 percent of the FPL, the application may be denied, and the applicant can appeal this determination.

Family Size

In determining eligibility for Medicaid, the Marketplace will not have access to the IRS database in order to verify family size. Medicaid can either rely on the "self-attestation" of an applicant or use other electronic databases to verify an applicant's family size.

In a household where the non-custodial parent claims a child as a dependent on his or her income tax return, the child will be included in the household where the child lives — not the non-custodial parent's household — for Medicaid determination.

Income and Family Size Determine FPL

The MAGI income and family size taken together determine the federal poverty level, and the FPL determines which insurance program an individual or family qualifies for. Pregnant women and infants under age one are eligible for Medicaid if they are in families earning less than 155 percent of the FPL. Children between the ages of one and 19, parents and caretakers, and adults without children are eligible if they are in families earning less than 138 percent of the FPL. See Chart 3 for income limits by FPL and family size which will be in effect until spring 2014. The FPL is updated every spring to reflect inflation.

Age, Residency and Pregnancy

For age, residency and pregnancy status, the Marketplace will accept self-attestation unless the Marketplace has information to the contrary, which is unlikely.

Citizenship

An applicant can attest that he or she is a US citizen, but the Marketplace must electronically verify citizenship with the Social Security Administration. If the SSA cannot verify the citizenship of an applicant and all of the family members who are applying for Medicaid benefits, then the Marketplace will electronically check with other databases to attempt to verify citizenship. If the Marketplace is unable to verify citizenship, the applicant is given a period of time to provide additional documentation. If the

CHART THREE

Federal Poverty Level (FPL) by Family Size

Family Size	138% of FPL (family income limit for children > 1 year and adults < 65 years)	155% of FPL (family income limit for pregnant women and infants < 1 year)
1	$15,856	$17,810
2	$21,404	$24,040
3	$26,951	$30,272
4	$32,499	$36,502
	,	$,

discrepancy cannot be resolved, the Marketplace will make a determination based on the information it has. If the application is denied, the applicant can appeal.

This verification process can be confusing. What is important to understand, particularly for community assisters, is that the Marketplace will rely on electronic databases to determine income, family size, citizenship and residency even when there is conflicting data. Only when electronic databases are unable to resolve discrepancies will the applicant be required to provide additional documentation.

An example may be helpful. The Smith family consists of Roger, who is a mechanic and works for a local garage; Sally, who works at a local restaurant; and Amy, their three-year old daughter. Neither Roger's nor Sally's employer offers health insurance coverage. On October 1, 2013, Sally, who files the family's income tax return, goes to the Marketplace and enters her social security number and other personal information (home address, etc.) The Marketplace pulls up the most recent tax return and reports that the family income was $27,000 in 2012. Sally reports that Roger received a $500 salary increase in 2013, bringing their family income to $27,500, and she reports that she is pregnant. Since Sally is pregnant, the pregnancy benefits under Medicaid will count both her and her expected child. The Marketplace will also connect with the Social Security Administration and verify that all members of the Smith family are US citizens.

Given these circumstances, the Marketplace determines that Sally is eligible for Medicaid (pregnant and in a family earning less than 155% of the FPL), and her information is electronically forwarded to West Virginia's Medicaid program for enrollment. The Marketplace determines that Amy, the three-year old daughter, is eligible for CHIP, and her information is electronically forwarded to CHIP for enrollment. Roger qualifies for a private insurance policy (a QHP) and is eligible for both premium tax credits since he is in a family earning less than 400 percent of the FPL and cost sharing reductions since he is in a family earning less than 250% of the FPL. He will be given a list of private insurance policies to select from.

What is important to understand, particularly for community assisters, is that the Marketplace will rely on electronic databases to determine income, family size, citizenship and residency even when there is conflicting data. Only when electronic databases are unable to resolve discrepancies will the applicant be required to provide additional documentation.

A couple of observations about this example: Sally will not be asked about family resources. There is no asset test for people qualifying for Medicaid using the MAGI income determination. They can own their home or be renting, own a car, or have a savings account. It doesn't make a difference.

Nor can the Marketplace require a face-to-face interview. Eligibility in the Marketplace and enrollment in Medicaid can occur electronically, by phone or by mail.

Sally will need to "attest" that her family's current monthly income is $2,292, so she can qualify for Medicaid. Since this amount is "reasonably compatible" with the IRS's database, the Marketplace accepts this representation from Sally. Similarly, Sally attests that the family's projected income will be $27,500 in 2014, so that Roger will get the correct amount of subsidies for premium assistance and cost sharing reduction. Since this amount is reasonably compatible with the IRS database, the Marketplace accepts Sally's representation.

The Marketplace must also accept Sally's attestation that she is pregnant, unless they have information to the contrary. Sally will also need to attest that her family intends to live in West Virginia. As part of obtaining a QHP for Roger, Sally will need to attest that she and Roger plan to file a joint IRS tax return and claim two children as dependents at the end of tax year 2014.

She cannot solely attest regarding whether she, Roger and Amy are US citizens. This must be checked electronically with the Social Security Administration or other databases, since unauthorized immigrants do not qualify for Medicaid, CHIP or subsidized private insurance plans in the Marketplace.

Changes in the Children's Health Insurance Program (CHIP)

CHIP provides health insurance for the uninsured children of families earning too much for Medicaid and less than 300 percent of the FPL. As a result of the higher Medicaid income limits, many children currently covered by CHIP will be moved to Medicaid. Approximately 10,500 children, or just over 40 percent of CHIP's current enrollment, will no longer be eligible for CHIP because they have become eligible for Medicaid.

This is a significant change. Some parents highly value the CHIP coverage for their children and may resent their child being placed in Medicaid which they may view (incorrectly) as a welfare program. Additionally, there may be some disruption of provider relationships if the child's pediatrician or other provider accepts reimbursement from CHIP but not Medicaid.

Families with incomes between 200 and 300 percent of the FPL are currently required to pay a premium for enrolling their children in CHIP. The premium is $35 per month for each child and capped at $70 per month for two or more children. If CHIP continues to charge this premium, families whose children are covered by CHIP and who purchases a QHP in the Marketplace to cover the rest of the family members, will pay both the CHIP premium and the QHP premium.

Families earning between 300 and 400 percent of the FPL, however, will only pay the premium for the QHP and not a separate CHIP premium since they earn too much for their children to qualify for CHIP coverage. Instead these children will be enrolled in the QHP.

III: Health Insurance Marketplace: Qualified Health Plans

If the Marketplace is constructed properly, consumers should be able to easily compare policies and choose one that best fits their needs. That is the potential of the Marketplace

Enrolling in a qualified health plan (QHP) in the Marketplace is more complex than enrollment in Medicaid and CHIP and requires applicants to make a series of decisions. Once enrolled, however, financial assistance for eligible persons is applied immediately, so people don't have to pay for health care or insurance premiums up-front and then be reimbursed later. This is a key feature of what makes the ACA affordable.

Once applicants have been determined eligible for a QHP, they should be able to easily compare different insurance plans. They can see what the monthly premium, deductible and copayments will be. They can check to determine if their doctors and hospitals are in a plan's network and if the prescription drugs they are taking are on the insurance company's drug formulary.

Applicants will have access to an eight-page summary of benefits and coverage written in plain English, spelling out what is covered and what is excluded in the insurance policy. The summary of benefits and coverage will also include examples of approximately what their plan will cost a typical Type II diabetic patient and what a normal child delivery will cost to help consumers compare the value provided by different insurance plans. In future years, the web site will show the results of consumer satisfaction surveys for each insurance plan and whether the companies are providing a high quality insurance product.

For consumers who want to make informed decisions about this important purchase, the Marketplace web site should provide a lot of detailed information. If the Marketplace is constructed properly, consumers should be able to easily compare policies and choose one that best fits their needs. That is the potential of the Marketplace.

Timelines

The Marketplace will begin making eligibility determinations on October 1, 2013, with coverage beginning as early as January 1, 2014. The initial enrollment period is from October 1, 2013 through March 31, 2014. After this initial enrollment period, individuals and families will only be allowed to enroll in QHPs during the annual enrollment period and special enrollment periods. Annual enrollment periods are limited to seven weeks each fall: October 15 through December 7. Appendix C provides a list of reasons for special enrollment periods, such as birth of a child, loss of employer-sponsored coverage, marriage or divorce.

Applicants who enroll in a QHP prior to December 15, 2013 will have their insurance policy become effective on January 1, 2014. Applicants who enroll between December 16 and December 31, 2013 will have an effective date of February 1, 2014. This general rule also applies to subsequent enrollment. Enrollment prior to the 15th of the month will become effective the first day of the following month, and enrollment on or after the 16th of the month will have an effective date on the first day of the second following month.

Eligibility for Qualified Health Plans, Premium Assistance and Cost Sharing Assistance

To be eligible for a QHP in the Marketplace, an applicant must (1) be a US citizen or an immigrant who is lawfully present in the US, (2) be a resident or intend to be a resident of West Virginia and live in one of the eleven regions of the state established by the Offices of the Insurance Commissioner (Appendix C has a map of these regions), and (3) not be incarcerated.

In order to qualify for advance payment of premium tax credits in the Marketplace, applicants must meet the QHP qualifications as well as the following criteria:

1. Must have family income between 100 percent[6] and 400 percent of the FPL during the benefit year (in this case 2014).[7] Higher income applicants may purchase QHPs in the Marketplace but will be required to pay the total monthly premium.

2. Cannot be eligible for other health insurance coverage, such as employer sponsored insurance coverage (with two limited exceptions that are discussed later), Medicare, Medicaid and PEIA. A dependent child cannot qualify for premium assistance if he or she is eligible for CHIP; and

3. Are expected to file a tax return following the year in which they receive benefit (in this case following 2014).

Additionally, there are subsidies to assist individuals and families with the cost of deductibles, copayments and co-insurances. These subsidies, called cost sharing reductions (CSR), are available to individuals and families who are expected to earn less than 250 percent of the FPL during the coverage year (for example, 2014). These subsidies are examined later in this section.

Citizenship and Lawfully Present Immigrants

Being a US citizen or a lawfully present immigrant is one qualification for eligibility for QHPs. When an applicant completes an application on the Marketplace web site, he or she will "attest" whether they and all of the members of the family who are seeking insurance coverage are US citizens. The Marketplace will verify this through the Social

6 Note that the income level for the advance payment of premium tax credits starts at 100% of FPL, not 138%.

7 In states that expand Medicaid up to 138% of the FPL, legally present immigrants who have been in the US for less than five years, and therefore do not qualify for Medicaid can receive tax credits below 100% of the FPL.

Lawfully present immigrants can qualify for QHP benefits.

Security Administration (SSA). If the SSA verifies an applicant and all members of the family who are seeking coverage as US citizens, then the Marketplace determines that they meet the citizenship qualifications.

If the SSA cannot verify citizenship of an individual or all of the family members seeking coverage, the Marketplace will electronically check with other databases. If the discrepancy cannot be resolved, then the Marketplace is required to provide the applicant with a 90-day period in which to provide additional documentation. During this grace period, if the applicant meets all other eligibility criteria, the applicant (and family members) can be enrolled in a QHP, although they may be required to pay back any subsidies that they receive if their application is denied. Ultimately, if the discrepancy cannot be resolved, the Marketplace will make a decision based on the information it has. If the applicant is denied, the applicant has the right to appeal.

Unlike Medicaid, where generally legal immigrants do not qualify, lawfully present immigrants can qualify for QHP benefits. Their status is verified through Homeland Security. If Homeland Security fails to verify the applicant's (and all members of the family who are seeking coverage) lawful present status, the Marketplace will electronically check other databases in order to determine the immigration status of the applicant and applicable family members. If the Marketplace cannot resolve this discrepancy, then the applicant is given 90 days to provide additional documentation. If the applicant meets all other eligibility criteria, the applicant (and family members) can be enrolled in a QHP, subject to possible reconciliation. Ultimately, if the discrepancy cannot be resolved, the Marketplace will make a decision based on the information it has. If the applicant is denied, the applicant has the right to appeal.

Residency and Incarceration Status

Unless the Marketplace has information to the contrary, it will accept the "self-attestation" that an applicant intends to reside in West Virginia and will live in one of the eleven rating regions established by the Offices of the Insurance Commissioner. Insurance companies will be allowed to charge higher or lower premiums in these regions. The Marketplace will also accept the self-attestation that an applicant is not incarcerated other than pending disposition of charges (meaning an individual who is incarcerated pending resolution of their case).

Income and Family Size

As with Medicaid, the Marketplace will use the modified adjusted gross income (MAGI) with a few exceptions.[8]

8 There are exceptions from taxable income in determining MAGI income. Income not included in the calculation of MAGI includes educational grants and awards other than living expenses and certain income to American Indians and Native Alaskans. Included in the MAGI calculation is all Social Security income, foreign income and income from tax exempt interest.

Importantly, eligibility for premium and cost sharing subsidies in the Marketplace is based on the benefit year, which in this case is 2014. When an applicant is completing an application on the Marketplace web site, the Marketplace will pull up the applicant's latest IRS return (the 2012 returns) and display the applicant's MAGI income. If the applicant knows that he or she has received additional income during 2013, or is likely to receive additional income during 2014, he or she will be given an opportunity to update the MAGI displayed by the IRS.

If an applicant and the IRS figures differ, the Marketplace will attempt to use other databases to verify the applicant's income, checking, for example, if the applicant or family member recently filed for unemployment benefits. If these other databases cannot resolve the discrepancy and the applicant's income is higher than the IRS's reported income, the Marketplace accepts the higher income. If the applicant's income is lower, but the difference is less than 10 percent, the Marketplace accepts the applicant's MAGI income projection. If the applicant's projection is more than a 10 percent reduction in income from the IRS figure and the other databases cannot resolve the discrepancy, then the applicant is given 90 days to provide additional information. If the applicant meets all other eligibility requirements, the applicant can be enrolled in a QHP but will be subject to repayment of any subsidy received if their application is ultimately denied.

As with Medicaid, the Marketplace will not have access to the IRS database in order to verify an applicant's family size. The Marketplace will either have to rely on the "self-attestation" of the applicant or use other electronic databases to verify family size. Taken together, income and family size will determine an individual's or family's FPL, and the FPL determines whether the individual or family qualifies for premium subsidies and/or cost sharing subsidies.

Unlike Medicaid, in a family where the non-custodial parent claims a child as a dependent, that child will be included in the family size of the non-custodial parent, not in the family where the child lives, for determining eligibility for premium and cost sharing subsidies.

It should be noted that couples who file separate income tax returns after 2014 will not be eligible for premium tax credits. Beginning in 2014, couples must file a joint return in order to qualify for premium assistance.

Essential Health Benefits

Every policy sold in the Marketplace is required to provide "essential health benefits." These benefits are designed to resemble a typical small business policy and include doctor visits, inpatient and outpatient services, prescription drug coverage, preventive measures without a deductible or copayment, maternity and newborn care, mental health and substance use disorder services, labs and x-rays, etc. (See Appendix A for additional information on essential health benefits.)

CHART FOUR

Plan Levels and Features

Plan Level	Percentage of claims paid by the insurance company	Average percentage of claims paid by consumers	Are subsidies available for premium assistance?	Are subsidies available for deductibles, copayments and co-insurances?
Bronze	60%	40%	Yes, for those earning 100%-400% FPL. Assistance is based on cost of the second lowest Silver plan; consumer pays difference for higher-cost plans or receives a reduction for bronze plans	No
Silver	70%	30%		Yes, for those earning less than 250% of FPL
Gold	80%	20%		No
Platinum	90%	10%		No

Choice of Plans

The Marketplace can offer four plan levels (platinum, gold, silver or bronze) with different "actuarial values."[9] Additionally, there will be catastrophic coverage for individuals and families under age 30.[10]

Actuarial value is the percentage of the total covered expenses that the insurance company pays versus what, on average, consumers pay. The percentages range from the platinum plan, where the insurance company pays 90 percent of legitimate claims and consumers pay on average ten percent, to the bronze plan, where there is a 60/40 percent split between the insurance company and consumers. (See Chart 4.)

As the average percentage of total claims paid by consumers increases, the monthly premium decreases. A platinum plan will have very low deductibles and copayments but higher premiums. Conversely, a bronze plan will have higher deductibles and copayments but lower monthly premium payments. It is important for consumers to weigh the benefits of paying lower or higher premiums versus lower or higher deductibles and copayments based on how much coverage they expect to use.

Premium Tax Credits

The Marketplace offers assistance with QHP premiums in the form of advanceable premium tax credits. "Advanceable" means that the federal government will pay the credits directly to the applicant's insurance company on a monthly basis. Consumers will not have to pay the full cost of the premium up front and wait for their tax credits at the end of the year.

9 Insurance companies in the Marketplace are only required to offer gold and silver plans but may also offer platinum and bronze plans in the Marketplace.

10 The catastrophic coverage is also available to individuals and families with premium costs that are more than 8 percent of their income.

An example might help to explain what is meant by a tax credit being advanceable. The Jones family consists of David, who works as an electrician and earned $35,000 in 2012, and his wife Debbie, who is a teacher and also earned $35,000 in 2012. Neither David nor Debbie is offered employer sponsored insurance coverage. They have two children, Mark and Alice. The family income is $70,000, approximately 300 percent of the FPL for a family of four, which is too high to qualify for Medicaid but low enough to qualify for the advance payment of premium tax credits. According to the calculator on the Kaiser Family Foundation's web site (www.kff.org), the total family premium will be $12,130 a year or $1,011 a month.[11] The Jones family will pay a monthly premium of $552, and the IRS will pay $459 a month directly to the insurance company they select. If the tax credits were not advanceable, then the Jones family would have to pay the entire premium of $12,130 and then file for a refund of $5,504 ($459 times 12) by the following April.

One of the decisions that an individual or family will need to make after the Marketplace determines that they qualify for an advance premium tax credit is what level of benefit best fits their needs. (See Chart 4.) The advance premium tax credit is tied to the second lowest silver plan in West Virginia's Marketplace. If the applicant selects a gold or platinum plan, they will have to pay the difference in premiums. Or they can select a bronze plan, and their monthly premium payment will be reduced by the difference between the premiums in the second lowest silver plan versus the premium in the bronze plan.

Cost Sharing Reductions with Silver Plans

There are also federal subsidies that reduce the amount of deductibles, copayments and co-insurance that a family pays. These cost sharing reductions are limited to families earning less than 250 percent of the FPL.

The cost sharing reduction subsidies are available ***only*** with silver plans. If an individual or family selects a platinum, gold or bronze plan, they are not eligible for the cost sharing reduction subsidies even if their income is below 250 percent of the FPL. Individuals and families with incomes below 250 percent of the FPL who select a silver plan will have the following reductions in their cost sharing (deductibles, copayments and co-insurance):

CHART FIVE

Federal Poverty Level (FPL) by Family Size

Federal Poverty Levels	Cost of the claims paid on average by an individual or family
100 to 149% of FPL	6%
150 to 199% of FPL	13%
200 to 249% of FPL	27%
250% and above	30%, which is the average amount paid by ndividuals and families in a silver plan

11 This example from the Kaiser Family Foundation is based on 2013 data.

For individuals and families earning between 100 percent and 199 percent of the FPL, having their cost sharing responsibility reduced from the standard 30 percent to either 6 percent or 13 percent of claims is a significant savings in out-of-pocket cost. However, for those individuals and families who are between 200 and 249 percent of the FPL, the percentage of claims that they are responsible for is only reduced from 30 percent to 27 percent which won't have much of an impact.

Employer-Sponsored Insurance Coverage

With two exceptions, individuals and family members are ineligible for premium tax credits and cost sharing reductions if they are eligible for employer sponsored health insurance coverage or other insurance coverage (Medicaid, Medicare, etc.) The exceptions for employer-sponsored plans are:

1. **Unaffordable.** An employer plan is considered unaffordable if the employee share of the premium costs exceed 9.5 percent of the employee's family income for a single policy. This definition of being unaffordable applies to the cost of a single plan even if the employee has selected a family plan with his or her employer. If the single plan costs an employee less than 9.5 percent of his or her family's income, but he or she finds the employer-sponsored family plan to be prohibitively expensive, the remaining family members cannot go to the Marketplace and receive premium subsidies. If an employer does not offer family coverage, then the family members will be eligible for premium tax credits if they meet other eligibility requirements.

2. **Not comprehensive.** An employer's insurance policy is not considered comprehensive if it has an actuarial value of less than 60%. Plans where the insurance company pays less than 60% of the claims and the employees pay more than 40% of the claims in deductibles, copayments and co-insurances are not considered comprehensive.

   In these two cases, employees can enter the Marketplace and apply for tax credits.

Reconciliation

It is vitally important that individuals and families accurately report their projected income and family size for 2014. The IRS tax returns that will be available to the Marketplace's web site and call center will be the 2012 returns. If an individual or family does not report changes in family size or increases in income that they have already received, or changes that occur after enrollment, they may receive larger tax credits than they are entitled to.

After an individual or family files their taxes for 2014, the IRS will conduct a reconciliation to determine whether individuals and families received tax credits above what they were entitled to and may seek repayment. The amount of repayment is capped based on income, but individuals and families could still face significant repayments, which are due in a lump sum, if they do not accurately report their income

CHART SIX

Reconciliation

Income as a percentage of poverty	Maximum repayment
Less than 200%	$300
200% to 299%	$750
300% to 399%	$1,250
More than 400%	The entire amount of over-payment

and family size. The limits on repayment are for a single person are listed in Chart 6. Limits are double these amounts for joint filers.

The premium tax credits are "refundable," meaning that if an individual or family did not receive the premium tax credit they were entitled to, they will get a refund from the IRS for the difference.

Out-of-pocket Protection

All plans sold in the Marketplace are required to have out-of-pocket maximum limits. Out-of-pocket maximums are the most that an individual or family will have to pay in deductibles, copayments and co-insurances during the year for essential health benefits. After an individual or family reaches their out-of-pocket maximum, the insurance company pays the entire cost of all legitimate claims for the remainder of the year. The out-of-pocket maximums are tied to income. Chart six shows what the out-of-pocket maximums are estimated to be in 2014.

CHART SEVEN

Estimated Out-of-pocket (OOP) Maximum in 2014

Federal Poverty Levels	OOP Maximum for a single plan	OOP Maximum for a family plan
Less than 200% FPL	$1,963	$3,967
200 to 250% of FPL	$2,975	$5,950
250% and above	$5,950	$11,900

IV: The Small Business Health Option Program (SHOP)

The SHOP Marketplace is designed to allow small businesses, those with fewer than 50 full-time equivalent employees, the option of purchasing group health insurance for themselves and their employees. As with the individual and family Marketplace, the SHOP Marketplace will sell insurance plans through a web site, by phone, by mail or with personal assistance. Both the SHOP Marketplace's web site and call center will be operated by HHS.

Only qualified health plans (QHPs), those approved by the West Virginia Offices of the Insurance Commissioner, can be sold in the SHOP Marketplace. Insurance companies will be required to offer gold and silver plans, those covering 80 and 70 percent of the claims with employees being responsible for, on average, 20 and 30 percent of the claims, respectively. Insurance companies can, but are not required to, offer platinum plans, where the insurance company pays 90 percent of the claims, and bronze plans, where the split is 60 percent paid by insurance companies and 40 percent by consumers.

All plans sold in the SHOP must cover the essential health benefits, including: doctor office visits, inpatient and outpatient services, mental health and substance use disorder services, prescription drugs, lab and x-rays, preventive services without charging the consumer a deductible or copayment, maternity and newborn care, and pediatric vision care. (See Appendix A for more information on essential health benefits.)

Timelines

The SHOP Marketplace will begin accepting applications from small employers beginning October 1, 2013 for coverage effective as early as January 1, 2014. There is no set enrollment period for small businesses. They can enroll employees at any time. When a small employer does enroll, the coverage will be for twelve months. The employees of small employers are eligible for most of the special enrollment periods and can change insurance companies when there is a birth, divorce, etc. (See Appendix C for a list of the criteria for special enrollments).

Enrollment Process

Starting October 1, 2013, a small business can select one, and only one, QHP for its employees. Beginning in 2015, employers will be able to select multiple QHPs, allowing employees to select a health plan that best fits their needs. The employer will establish what percentage of the total monthly premium that the employer will be responsible for. The small business will provide the SHOP Marketplace with a list of employees. The small business must make all full-time employees eligible for coverage unless there is a waiting period for new employees. Seventy percent of the employees must participate in the insurance coverage in order for an employer to use the SHOP Marketplace.

Any employee who is on the employer's list can access the SHOP Marketplace through a web site, toll-free number, by mail, or with in-person assistance. The SHOP Marketplace

will include a calculator that provides the employee with the monthly premium, deductibles, copayments and co-insurances that the employee will be responsible for.

There will be links to the insurance company's network so that employees can determine whether his or her doctor or hospital is in the network. There will also be a link to the insurance company's formulary, so the employee can determine whether the prescription drugs being taken by the employee or family members are on the insurance company's formulary. Regretfully, the SHOP Marketplace will not provide for employee choice in 2014. So even if an employee finds that his or her doctor is out of network or a prescription drug that he or she is taking is off the insurance company's formulary, there is nothing that the employee can do. Employees are limited to the one QHP that their employer has selected. Beginning in 2015, that should change, and an employer can select several different QHPs, and the employees can select the one QHP that best fits his or her family needs.

Tax Credits for Small Businesses

Since 2010, certain small businesses have been eligible for tax credits to offset the premium costs of providing health insurance to their employees. To be eligible, small businesses must have fewer than 25 full-time equivalent employees who earn on average less than $50,000 a year. Small businesses with fewer than ten employees, who earned on average less than $25,000 annually, qualified for the maximum tax credit which is 35 percent of the employer's contribution of the premiums. In 2010 through 2013, the tax credit for nonprofit small employers is a maximum of 25 percent per year. An employer must pay at least 50 percent of the total premium in order to qualify for the tax credit.

Beginning in tax year 2014, the maximum tax credit for for-profit employers increases to 50 percent of the employer's premium for small businesses with ten or fewer employees earning less than $25,000 on average. The maximum tax credit for nonprofits increases to 35 percent of the employer's share of the premium. After 2014, employers can only take the tax credit for two years, and employers must purchase insurance through the SHOP Marketplace in order to qualify for the tax credit.

Many small businesses owners have found the tax credits to be difficult to apply for, and although it only provides limited relief for the high costs of health care, it is certainly better than no tax credit for small businesses.

APPENDIX A

Essential Health Benefits

All qualified health plans sold in the Health Insurance Marketplace and the SHOP Marketplace, as well as Medicaid benefits for the MAGI population, must include the essential health benefits. For all three policies, the essential health benefits must include the following broad outline of benefits:

- Ambulatory patient services
- Inpatient and outpatient hospital services
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Laboratory services
- Clinically effective preventive services without payment of deductibles, copayments or coinsurances
- Chronic disease management
- Pediatric services, including vision health benefits
- Rehabilitative and habilitative services

Exactly what these benefits mean was established for polices sold in the Health Insurance Marketplace and the Shop Marketplace when West Virginia selected the largest small group plan sold in the state: Highmark Blue Cross Blue Shield Super Blue 2000 plan.

Under this plan, for example, applied behavior analysis for the treatment of autism is a covered service as an essential health benefit, since it was included in Highmark's plan. Also, since Highmark's plan did not cover pediatric oral health, the CHIP oral health benefit was adopted as a means of "backfilling" this benefit.

Also, while rehabilitative services were covered by Highmark, habilitative services were not. An example of a rehabilitative service is that a patient has a stroke and loses his or her speech. They go to a speech therapist in order to regain their speech. An example of a habilitative service is a child is developmentally delayed and visits a speech therapist in order to "gain" (not regain) his or her speech. The Offices of the Insurance Commissioner will require plans sold in both Marketplaces to cover habilitative services that "gain, keep or improve" daily living skills.

Medicaid is still in the process (as of April 2013) of selecting a "benchmark" plan to fill in the details of the essential benefits for the MAGI population. Medicaid has several benchmark options to select from. They can select traditional Medicaid benefits, one of the federal employee plans, one of the small group market plans, the Public Employee Insurance Agency plan, a HMO plan sold in the state, a "Secretary approved" plan, which is a plan approved by the Secretary of HHS, or a "benchmark approved" plan. Any plan selected by Medicaid must cover family planning services and supply, early and periodic screening, diagnostic and treatment (EPSDT) for children under age 21, and mental health parity. Which plan they select will have an impact on the thousands of West Virginians who enroll in the MAGI Medicaid programs.

Family Size	100%	138%	155%	250%	300%	400%
1	$11,490	$15,856	$17,810	$28,725	$34,470	$45,960
2	15,510	21,404	24,040	38,775	46,530	62,040
3	19,530	26,951	30,272	48,825	58,590	78,120
4	23,550	32,499	36,502	58,875	70,650	94,200
5	27,570	38,047	42,734	68,925	82,710	110,280
6	31,590	43,594	48,964	78,975	94,770	126,360
7	35,610	49,142	55,196	89,025	106,830	142,440
8	39,630	54,689	61,426	99,075	118,890	158,520

APPENDIX C

Map of the OIC Established Regions of the State

APPENDIX B

2013 Federal Poverty Levels by Family Size

APPENDIX D

Criteria for Special Enrollment Periods

The following are the special enrollment periods that allow individuals or families the opportunity to enroll in a qualified health plan or select a different qualified health plan in the Health Insurance Marketplaces at times other than the initial enrollment period (October 1, 2013 through March 31, 2014) or regular enrollment periods (October 15 through December 7, 2014 and each year thereafter). An individual or family can enroll in or change their QHP during a 60-day period following an occurrence outlined below:

- Birth
- Adoption
- Placement for adoption
- Loss of other minimum essential coverage (any event that triggers a loss of eligibility for other minimum essential coverage)
  - Decertification of a qualified health plan
  - Dependent loses other minimum essential coverage
  - Legal separation or divorce ending eligibility of a spouse or step child
  - End of dependent status
  - Death of an individual leading to ineligibility for covered dependents
  - Termination of employment or reduction in hours
  - Relocation outside of the service area of the qualified health plan
  - Termination of employer contribution
  - Exhaustion of COBRA benefits
  - Reaching a lifetime limit on all benefits in a grandfathered plan
  - Termination of Medicaid or CHIP
- Gaining of a dependent or becoming a dependent through marriage
- Gaining dependents through other life events
- Gaining status as a citizen, national, or lawfully present individual
- Error in enrollment
- Current qualified health plan violates a material provision of its contract in relation to the individual or dependents
- Newly eligible or newly ineligible individuals for advance payments of the premium tax credit or have a change in eligibility for cost sharing reductions
- A permanent move
- Exceptional circumstances as determined by the Marketplace and HHS such as a natural disaster

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